| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 003350 | A. BUILDING: _____ B. WING _____ | 08/16/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST VINCENT SETON SPECIALTY HOSPITAL, INDIANA | 8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>The visit was for the investigation of a State complaint.<br><br>Complaint Number: IN00204950<br>Unsubstantiated: Lack of sufficient evidence.<br><br>Date: 8-16-16<br><br>Facility Number: 003350<br><br>St Vincent Seton Specialty Hospital is in compliance with 410 IAC 15-1.5-6 Nursing service, Indiana Hospital Licensure rules.<br><br>QA: 8/25/16 jlh | S 000 | | |